

WEST VIRGINIA I/DD WAIVER APPLICATION

**Applicant must be at least 3 years of age on the date of submission*

Applicant Information			
First Name, MI, Last Name		Date of Birth	
Mailing Address*			
Phone Number		Social Security Number	
Medicaid Number (if applicable)		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address (if applicable)		County of Residence	
Legal Representative Information <i>(select one of the boxes below)</i>			
<input type="checkbox"/> N/A (member is own representative)	<input type="checkbox"/> Parent of a Child under the Age of 18	<input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> WVDHHR Guardian
First Name, MI, Last Name		Phone Number	
Mailing Address			
Email Address (if applicable)			
Non-Legal Representative Information <i>(if applicable)</i>			
First Name, MI, Last Name		Relationship to Applicant	
Address			
Phone Number		Email Address (if applicable)	
Applicant/Legal Representative Signature			
<input type="checkbox"/> I certify the above information is accurate and complete to the best of my knowledge. I understand the information provided in this document will be treated confidentially. I certify that the above-named applicant is permanent resident of West Virginia. **Proof of residency must be included with this application including a photo ID or utility bill showing the WV physical address in the name of the applicant (or legal representative in the case of a minor).			
Printed Name of Applicant or Legal Representative		Date	
Signature of Applicant or Legal Representative		Date	
Form Submission (forms may be mailed, faxed or emailed)			
Mail: APS Healthcare, Inc. – WV 100 Capitol Street, Suite 600 Charleston, WV 25301 Fax#: (866)521-6882 Email: widdwaiver@apshealthcare.com If you have not heard back from APS Healthcare within 5 business days, please call toll free 866-385-8920.			
DO NOT WRITE BELOW THIS LINE			
<input type="checkbox"/> Application can be processed (applicant is at least 3 years of age at time of application, and proof of residency was included). <input type="checkbox"/> Application cannot be processed and will be closed (include description): _____			
Signature of UMC Representative Receiving Form		Date	